Harbor of Hope, Inc.

Assistance Application

___New Application ___ Application Renewal

Applicant Name: _____ Phone: _____

Applicant Home address: _____County: _____

Applicant personal email address: _____

Attending Physician Name: *(please print)* _____

Assistance to be provided: *(please select 1 or more requests)*

1) _____ Amount $_____
2) _____ Amount $_____
3) _____ Amount $_____

Example ____GA Power_____ Amount $_____118.35_____

Applicant Signature: _____Date:_____

Attending Physician USE ONLY

I confirm that the above named applicant: *(check appropriate box)*

_____ Cancer diagnosed

_____ Currently receiving ACTIVE treatment for cancer

Physician Signature: _____Date:_____

Harbor of Hope, Inc. USE ONLY

Date of Application Received: _____

Verification of Information: _____

Approved: _____Date Approved: _____

Requested Amount: _____Board Approved Amount: _____ Request #____ Total: $ _____

Harbor of Hope, Inc. application guidelines:

- Membership in Harbor or Hope, Inc. is not required for consideration.
- Application MUST be signed by attending physician to be considered by Harbor of Hope, Inc.
- Include supporting documents: receipt or bill with submitted application. Only completed applications will be considered.
- Please allow 10-15 business days for application decision.
- Reimbursement is subject to Harbor of Hope, Inc. funds available.
- Upon approval funds will be sent to the applicant. Allow 3-4 weeks for receipt of funds.
- Applicants may apply no more than two times within a 12 month period. Application is effective for 12 months.
- Assistance can be up to $500/year per the board's discretion.